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Finding the Balance

We are now well into summer and for some of us that means finding a better work/life balance, taking some time away to spend with family and friends doing some of those bucket list things that we rarely find the time for, while still ensuring that we fulfill our professional responsibilities in between!

Finding the balance in everything we do is important and also challenging. The articles in this issue are geared towards how to achieve that better balance across several important issues (health equity, strategic growth, increasing regulatory scrutiny, balancing management and governance structures, and finding the right balance of physicians on the board) and seeing the benefits that come from that. Our authors remind us this month as well about the costs of inaction.

I hope you can take this opportunity when you have some mental space to think about where your organization's imbalances are and what can be done to move disparate pieces into better alignment, remove barriers, and swim downstream together.

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Taking the Lead on Health Equity

By Duane Reynolds, Chartis

››› KEY BOARD TAKEAWAYS

Five Questions to Ask Your C-Suite about Health Equity

1. **Do we have a specific strategy to increase patient access?** The organization should ensure sufficient access to primary care, mental health care, and critical specialties. It is also important to make sure access initiatives aren't further compromising access for communities that have been marginalized.
2. **Does our organization collect the right type of data?** SOGI and REAL data and routine screenings for social drivers are essential data components.
3. **Are our data analytics tools sufficient?** Tools should equip leaders to understand healthcare disparities by clinical condition and then make data-driven decisions that drive high-reliability care.
4. **How does our organization ensure our AI applications benefit all patient cohorts without negatively impacting specific populations?** When the organization develops its AI use cases, leaders need to ensure that AI initiatives do not widen the divide in service and outcomes for different populations.
5. **How are we measuring performance on workforce metrics against benchmarks?** The board should understand key performance indicators the organization uses to benchmark workforce diversity, well-being, and turnover—and the recruiting and employee assistance practices deployed to address gaps.

As a hospital or health system board member, you have likely heard the phrase "health equity" frequently in recent years. But what is involved in advancing health equity and what role should board members play?

Health equity is when everyone has a fair and just opportunity to be as healthy as possible. Fundamentally, health equity is about doing what's right for patients and communities. It's about improving health and well-being for *everyone*, not just a select few.

It's not just the right thing to do; there's also a compelling business case and a cost of inaction.[1] Numerous laws and regulations supporting the advancement of health equity have proliferated over the last four years, stemming from healthcare disparities brought to light during the pandemic. Federal and state governments, along with payers and accrediting bodies, have instituted new health equity requirements. As a result, health equity is an imperative that impacts operational, financial, and clinical sustainability.

While addressing health inequity is no simple task, the board is uniquely positioned to ensure the organization converts good intentions into meaningful outcomes. The board can start by talking to the C-suite about how the organization is promoting health equity. Then it should support efforts by providing input and oversight, cultivating collaboration with community-based organizations, and ensuring appropriate financial stewardship.

Where to Start: Discussions with the C-Suite

The best way for healthcare organizations to advance health equity is to weave it into goals throughout the organization, from the board to frontline staff. Because we believe so strongly in the change this approach ignites, Chartis recently partnered with prominent executives and board members of industry-leading healthcare organizations on a collection of insights to help boards engage with the C-suite.[2] This article highlights our top-line insights that are especially important starting points.

1. Access

Disparities in healthcare access are systemic, deeply entrenched, and often multifaceted. They touch the lives of individuals and communities in ways that ripple through our society—impacting not only the quality of life but the very essence of what it means to live in a just and equitable world.

Hospitals and health systems need to make sure the communities they serve have timely, affordable care that is close and easily accessible to them. But offering equitable access to care is easier said than done.[3] Organizations must understand the barriers to care the community faces. They will likely need to make internal changes to things like appointment policies and compensation. And they may need to partner with other organizations to address systemic barriers, such as food insecurity, transportation, and health literacy.

Addressing these issues can solve many downstream problems, so it's important to understand how your organization is improving access for all populations.

2. Clinical Care

Organizations need to identify and understand where disparities in care exist. That means they need the right data inputs, including race, ethnicity, ancestry, and language (REAL) and sexual orientation and gender identity (SOGI) data.

> *Increasing diversity, equity, and inclusion at all levels of the organization helps hospitals and health systems reflect the communities they serve. This, in turn, helps reduce healthcare disparities and increases employee engagement.*

When organizations stratify this data and apply it to medical specialties, evaluating related medical conditions, disparities become clear. Organizations can then target improvement efforts.

For instance, conditions like lung disease are often underdiagnosed among Asian and Black patients. Similarly, the estimated glomerular filtration rate (eGFR), a diagnostic tool used by nephrologists, has delayed diagnosis and prevented millions of Black patients from getting timely kidney transplants and other much-needed care.

Board members need to understand the types of data the organization collects and how leaders are leveraging the data to improve clinical care and outcomes. Ideally, the organization is also working toward high-reliability care—providing the same high-quality, safe clinical care over time across all services.[4]

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1 "The Board's Unique Position to Advance Health Equity," Chartis, April 3, 2024.
2 See www.chartis.com/campaigns/leading-health-equity-insights-and-answers-boards-need-now.
3 Duane Reynolds, Sue Fletcher, and Joy Lewis, "Equitable Access to Care: Five Critical Questions Health System Boards Should Ask," Chartis, April 3, 2024.
4 Andrew Resnick, "High Reliability: The Board's Role in Ensuring Quality, Safety, and Organizational Reputation," E-Briefings, The Governance Institute, November 2023.

You Can't Cut Your Way Out: The New Growth Imperative

By Courtney Midanek, John Poziemski, and Max Timm, Kaufman, Hall & Associates, LLC

This article is part three in a series on reigniting the strategic plan after a turbulent era. Part one looked at the need to revisit strategy,[1] and part two focused on the board's fiduciary role in helping shape the best path forward.[2]

After several extremely challenging years, hospitals and health systems are experiencing modest improvements in financial conditions. According to Kaufman Hall National Hospital Flash Report data, year-to-date hospital operating margins stood at 3.8 percent through April 2024.[3] But while difficult cost containment around labor and service lines helped drive improvements in 2023—when hospital operating margins ended the year at 2 percent—healthcare organizations recognize they cannot simply cut their way to long-term sustainability.

The overall pace of margin recovery and performance improvement is not yet consistently above the 3–5 percent threshold that generally allows providers to generate capacity beyond routine capital needs moving forward. At the same time, the gap between high and low performers is widening: a Kaufman Hall analysis found that hospitals in the 75th percentile had year-to-date operating margins of 12.8 percent through April 2024, while those in the 25th percentile were at -2.6 percent.

Vectors of Growth

ORGANIC GROWTH

Strengthening core business
- New care models
- Pursuing operational excellence
- Developing new systems of care
- Technology-enabled growth initiatives

Entering or expanding into new markets
- Exploring new geographies and developing rural healthcare strategies
- Expanding into emerging market or population segments
- Developing new clinical programs and services

NON-ORGANIC GROWTH

Growth and partnerships
- Non-acute care partnerships with specialty providers and start-ups
- Payer–provider partnerships and affiliations

Beyond hospitals and health systems, leading organizations in other healthcare sectors are pursuing rapid growth. For instance, United Health and Humana control more than 45 percent of the Medicare Advantage market, while the top eight insurers control 80 percent.[4] This trend is also evident beyond healthcare, as many large, vertically integrated companies are also pursuing growth strategies as of late.

For hospital and health system boards and senior leaders, targeted growth strategies—both organic and inorganic—present an opportunity to strengthen their core businesses, expand into new geographies, and diversify profit pools. Together, these strategies are intended to help organizations take advantage of opportunities in their markets and create a pathway for sustained future success.

Pursuing Strategic Growth

While most organizations pursue growth at one time or another, achieving meaningful results requires discipline, persistence, and flexibility. And leading organizations no longer measure success through traditional measures such as inpatient volume share alone. Successful growth strategies will be measured against metrics such as acquisition of covered lives, increased influence over the spending of healthcare dollars, and direct (and downstream) impact on the total cost of care and experience.

Healthcare organizations are currently pursuing several interrelated "vectors of growth"—both organic and inorganic.

Organic Growth

Organic growth focused on strengthening the core business:

- **New care models** emphasizing an improved patient experience and a more sophisticated economic platform. Depending on the organization, these efforts might integrate healthcare financing and delivery with a given organization or partnership or optimize value within an existing integrated system. There are also a number of new incentive and payment models, including risk-based concierge medicine.
- **Pursuing operational excellence,** including efforts to improve patient care quality and the overall patient experience through more efficient service lines, networks, and marketing.
- **Developing new systems of care** to better serve patient populations, which may include offering new care settings.
- **Technology-enabled growth initiatives,** which often leverage artificial intelligence to steer clinical and operational improvements.

Organic growth through entering or expanding into new markets:

- **Exploring new geographies and developing rural healthcare strategies.** These activities can range from opening an urgent care center in a new geography within an existing market or partnering with another organization to expand a geographic presence across multiple markets.
- **Expanding into emerging market or population segments,** including efforts to enroll or serve Medicare Advantage and Health Insurance Exchange members.
- **Developing new clinical programs and services,** including new or expanded post-acute care, home health, and virtual care services. We are also observing the development of specialty-specific ambulatory surgical medical parks.

Non-Organic Growth and Partnerships

Successful growth strategies will require many organizations to pursue options for

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›› KEY BOARD TAKEAWAYS

As healthcare leaders and boards revisit growth strategies after a prolonged period of financial and operational turmoil, the opportunities outlined in this article present a potential road map forward. However, healthcare organizations will need to approach their options for strategic growth with their unique market realities and strategic viewpoint top of mind. As a starting point, boards should deliberate over three critical questions:

1. Is our market large enough?
2. Are we essential in our market?
3. How do we strengthen our competitive position?

1 Amanda Steele and Dan Clarin, "What Is Our Organization Trying to Be? Strategic Planning after Turbulence," *BoardRoom Press*, The Governance Institute, April 2024.
2 Dan Clarin, Courtney Midanek, and Amanda Steele, "Reclaiming the Board's Role in Strategy," *BoardRoom Press*, The Governance Institute, June 2024.
3 Erik Swanson, *National Hospital Flash Report: April 2024 Metrics*, Kaufman Hall, June 3, 2024.
4 Rylee Wilson, "UnitedHealthcare Has 28 Percent of Medicare Advantage Market Nationwide," *Becker's*, November 7, 2022.

The Increasing Scrutiny of Healthcare Transactions

By Bill Katz, Anna Hayes, and Eric Scalzo, Holland & Knight

The healthcare landscape has undergone a significant shift with more hospital transactions being announced and more private equity investment across the industry. A number of factors are fueling the rise of mergers and acquisitions (M&A) in the healthcare industry, particularly among hospitals and health systems, including rising costs (outpacing inflation), squeezing hospital margins, declining government funding (particularly as pandemic-related funding wraps up), nursing and physician shortages, and shifting payment models.

Overall, the M&A landscape in healthcare is complex, with a mix of financial pressures, strategic ambitions, and the need to adapt to a changing industry driving consolidation.

››› KEY BOARD TAKEAWAYS

- Identify the ideal end game and several alternatives and work backwards to assess what actions need to be taken in the near- and long-term to succeed.
- Educate yourself on the current M&A and regulatory landscape. Since 2020, there have been many shifts in the market that change the types of available partnerships and transactions structures and how deals get done, including timelines, due diligence, regulatory review, and more.
- In this new regulatory environment where whole hospital acquisitions are being more carefully evaluated and private equity ownership is being highly scrutinized, transactions will require additional due diligence.
- Remember your duties to the organization's mission and the provision of high-quality care in the geographic area served by the hospital or system. Does the partnering organization allow your system to advance its mission and provide the best care to patients?
- Make a plan to communicate with your constituents, including physicians, employees, and the public, and follow through on that plan regularly.
- While every situation has its own unique considerations, surrounding yourself with counsel who has advised on these types of transactions will allow you to more carefully navigate each situation and ultimately increase the odds of a successful transaction.

Hospital M&A

Hospital M&A activity increased in 2023, according to a report from Kaufman Hall. Nearly a third of the 65 announced transactions involved a financially distressed system—the highest proportion in recent history and up from 53 in 2022.[1] Predictions show that this trend is expected to continue in the coming year. While the number of deals is rising, the total revenue involved in these transactions is also significant, indicating larger and potentially more impactful mergers.

More distressed health systems seeking to consolidate follows a trend of hospitals posting consistently negative operating margins since 2022. As of November, median year-to-date operating margins sat at 2 percent, "well below the 3–4 percent range often cited as a sustainable operating margin for not-for-profit hospitals and health systems," according to Kaufman Hall.[2] For-profit and non-profit health systems also sought partnerships in "core" regional markets in 2023 to combine care networks and optimize the reach of scarce resources.

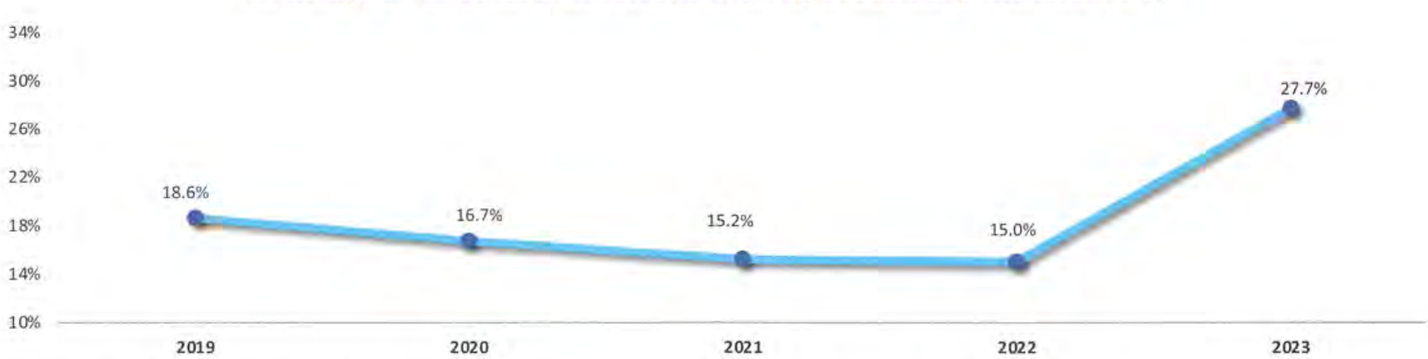
Private Equity Investment in Healthcare

For the past decade, private equity firms have invested more than $750 billion in a wide range of U.S. healthcare initiatives, including acquiring struggling hospitals, funding research and development in life sciences, and providing capital for physician practices.

Outcomes that come from private investments in healthcare services include improved efficiency, best practice sharing, access to capital, innovation, and positive patient outcomes. Private equity firms can provide much-needed capital for hospitals, which can be used to upgrade facilities, invest in new technologies, or expand services. This can be especially helpful for struggling hospitals that haven't fared as well due to market dynamics, increasing interest rates, and other economic factors.

Even so, private equity firms have drawn significant policy interest and scrutiny amid recent reports of surprise billing, rising out-of-pocket costs for patients, and increased healthcare spending in the U.S. Some of this has come to the forefront due to private equity-backed Steward Health Care garnering the news headlines over the last few months, given the 30-hospital system's filing for bankruptcy. Many news outlets have focused on this troubled story as an example of the negative impact of private

Percentage of Announced Transactions Involving a Financially Distressed Party



Source: Kaufman, Hall & Associates, LLC

1 Anu Singh, "Hospital and Health System M&A in Review: Financial Pressures Emerge as Key Driver in 2023," Kaufman Hall, January 18, 2024.
2 *Ibid.*

equity's role in healthcare. Steward, in its statement, indicated their financial distress resulted from the combined effects of low government reimbursement rates, increasing labor costs and inflation, as well as lingering impacts from the COVID-19 pandemic.[3]

Like any area, there are partners who are better options than others—there are good and bad actors across all industries. That is why it's always worth investigating potential partners and doing your due diligence. In looking at these shifts in market dynamics, hospital board members play a critical role in navigating these changes. This article explores the evolving regulatory landscape impacting hospital transactions and provides recommendations to help board members make informed decisions regarding their hospital's future.

The DOJ and FTC likely hope that by releasing "modernized" standards reflecting recent enforcement practices they might persuade more courts to consider and adopt aggressive interpretations of laws applicable to challenged transactions.

An Evolving Regulatory Landscape

While most analysts expect to see more whole hospital M&A and partnerships for ancillary services, some acknowledge that one aspect that could affect deal-making is the regulatory environment.

The Federal Trade Commission (FTC) has shown its willingness to oppose hospital mergers. The FTC has moved to block deals, particularly involving organizations in the same regions, saying they could lead to higher prices or reduced services for consumers.

There are two areas that hospital boards need to consider as they look at potential transactions and partnerships with third parties. The first is related to new merger guidelines released by the FTC and the U.S. Department of Justice (DOJ) Antitrust Division. The second is related to the rise in federal and state scrutiny of private equity investments in healthcare.

Merger Guidelines

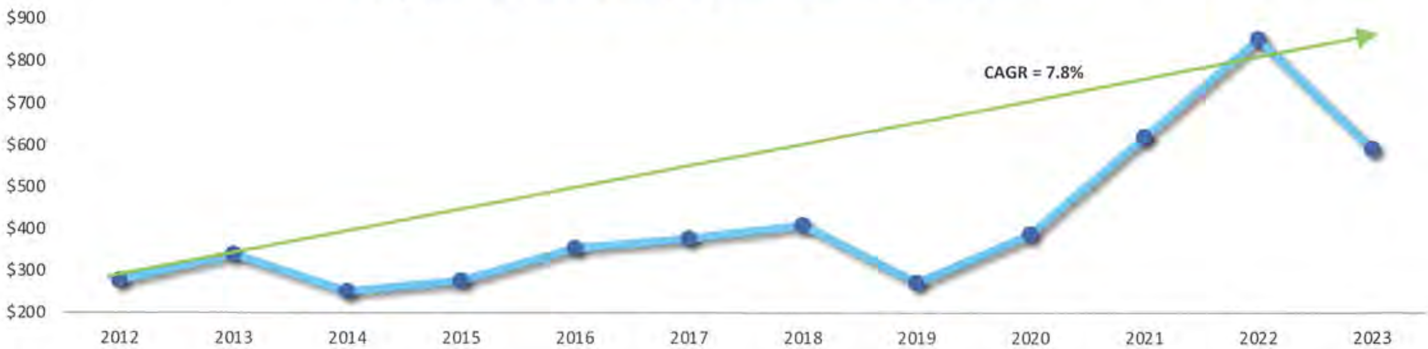
In December 2023, the FTC and DOJ Antitrust Division released their revised *Merger Guidelines*.[4] The guidelines significantly expand the number and types of transactions subject to antitrust challenge and apply stricter standards to proposed mergers between hospitals, insurers, and other healthcare providers. This reflects the FTC and DOJ's view that prevailing approaches to merger review have been too permissive and fail to identify and prevent transactions that harm consumers and workers, particularly in the healthcare industry.

The guidelines describe how the agencies evaluate whether transactions might violate Section 7 of the Clayton Act and "substantially...lessen competition, or tend to create a monopoly." The detailed explanations shed some light on the recent, more hostile, enforcement environment and will help companies understand in advance the nature of concerns that the DOJ and FTC might raise about contemplated transactions. Although the guidelines are not binding on courts considering merger challenges, past iterations have proven at least persuasive to many judges, and courts have incorporated standards and analyses from the guidelines into their decisions. The DOJ and FTC likely hope that by releasing "modernized" standards reflecting recent enforcement practices they might persuade more courts to consider and adopt aggressive interpretations of laws applicable to challenged transactions.

Several provisions in the guidelines are particularly relevant to mergers between hospitals, insurers, and other healthcare providers:

- **Presumption of harm:** The guidelines include presumptions that automatically render certain proposed mergers in the healthcare industry harmful to competition and make an extended review of these transactions a near certainty. For example, a presumption of harm arises when the combined firm resulting from a horizontal merger will have more than a 30 percent market share. The new presumptions are likely to have a chilling effect on potential acquisitions in the healthcare industry, as larger providers nearing the 30 percent threshold may be less likely to attempt to acquire even significantly smaller providers. Further, because there are usually a small number of hospitals in a given geographic market, the 30 percent market share threshold may serve as a difficult ceiling and prevent transactions in many areas, even when a transaction would benefit the community or fulfill a need.

Average Size of Smaller Party by Annual Revenue ($s in Millions)



Source: Kaufman, Hall & Associates, LLC

3 Alexander Gladstone, Laura Cooper, and Jonathan Weil, "Steward Health, Nation's Largest Physician-Owned Hospital Operator, Files for Bankruptcy," *The Wall Street Journal*, May 6, 2024.

4 "2023 Merger Guidelines," U.S. Department of Justice Antitrust Division.

- **Roll-up history**: To broaden the scope of transactions subject to review by the FTC and DOJ, the guidelines also focus on whether an acquiring company has employed a roll-up strategy of serial acquisitions—common in private equity. If there has been a roll-up history, the agencies may then consider the cumulative effect of the pattern or strategy on competition, rather than just focusing on the impact of the individual transaction on its own. The agencies have expressed concern that private equity firms, in particular, have avoided antitrust scrutiny through a series of smaller acquisitions, none of which individually would require a pre-merger notification filing under the Hart-Scott-Rodino (HSR) Act.
- **Smaller ownership stakes**: The guidelines also address transactions that involve less than full control of a target firm, so companies should not assume that they will avoid FTC and DOJ scrutiny by taking only a small ownership position in a target firm. The FTC and DOJ will assess whether a proposed transaction will result in either cross-ownership or common ownership that could be harmful to competition. An increased review of the potential effects of such transactions may impact the acquisition of non-controlling interests in joint venture limited liability companies (LLCs) or partnerships, which typically would not be reportable under the HSR Act.
- **Consideration of future market entrants**: The guidelines consider whether a proposed merger will eliminate a reasonably probable future market entrant, particularly in a concentrated market. This focus may present challenges for healthcare provider acquisitions, even by out-of-market providers. Previously, such transactions have not attracted significant antitrust scrutiny because the number of competitors in the market does not decrease. With this new consideration, agencies may advocate for potential market entrants to compete by building their own facilities from scratch, rather than by acquiring an existing facility in the market.

Investigating the Role of Private Equity

In addition to issuing updated *Merger Guidelines*, the FTC and DOJ are also collaborating with the Department of Health and Human Services (HHS) to investigate the role of private equity in the healthcare industry. In March 2024, representatives from the FTC, DOJ, and HHS participated in a public workshop examining private equity's role in the healthcare industry. A significant theme of the workshop focused on enforcers' belief that private equity investments have reduced the quality of care and worsened outcomes for patients and communities. Several speakers expressed concern about how private equity firms' financial motivations can undermine incentives to provide high-quality patient care, including how private equity firms often encumber healthcare providers with large amounts of debt and tend to have a short-term focus on financial performance.

To help identify potential enforcement opportunities, the FTC, DOJ, and HHS jointly launched a request for information (RFI) soliciting public comments on healthcare industry transactions—both reportable and not reportable under the HSR Act—involving insurers, private equity firms, and other alternative asset managers that may be negatively affecting patients, workers, and overall healthcare affordability. The FTC and DOJ also separately issued an RFI related to serial acquisitions across all industries, not only healthcare.

These actions show an increased government focus on competition issues in the healthcare industry specifically, and in private equity more generally.

Potential Consequences of Heightened Scrutiny

This increased focus on hospital transactions and private equity investment in healthcare systems obviously carries increased risk for parties interested in exploring future healthcare transactions. Government enforcers realize the power that comes with challenging proposed transactions. For example, in late 2023, John Muir Health and Tenet Healthcare chose to terminate the proposed acquisition by John Muir Health of Tenet's San Ramon Regional Medical Center in light of the FTC's lawsuit challenging that deal. The FTC touted this withdrawal as a major win for the agency. Parties may abandon other prospective deals if they fear there is a meaningful probability of a similar challenge.

However, there are plenty of benefits resulting from healthcare transactions, including those involving private equity investment. In light of the above statistics related to the high number of distressed health systems that have been involved with recent M&A activity, the infusion of resources can be particularly critical. In one recent example, the need to keep struggling facilities open was central to a court's decision denying the FTC's request for a preliminary injunction against Novant Health's bid to purchase two of Community Health Systems' hospitals in North Carolina. Deals that similarly work to keep facilities operational can succeed if they ensure continued community access to healthcare.

Looking Ahead

Potential deal participants can expect that the heightened scrutiny from government—whether FTC, DOJ, or other federal or state authorities—will only continue, and that these authorities will remain focused on competition in healthcare. States, in particular, are sometimes more nimble and adaptable with their enforcement strategies in response to changing industry conditions, including with proposed legislation addressing healthcare transactions and private equity ownership. We expect these authorities to proactively address healthcare transactions that they believe to be anticompetitive.

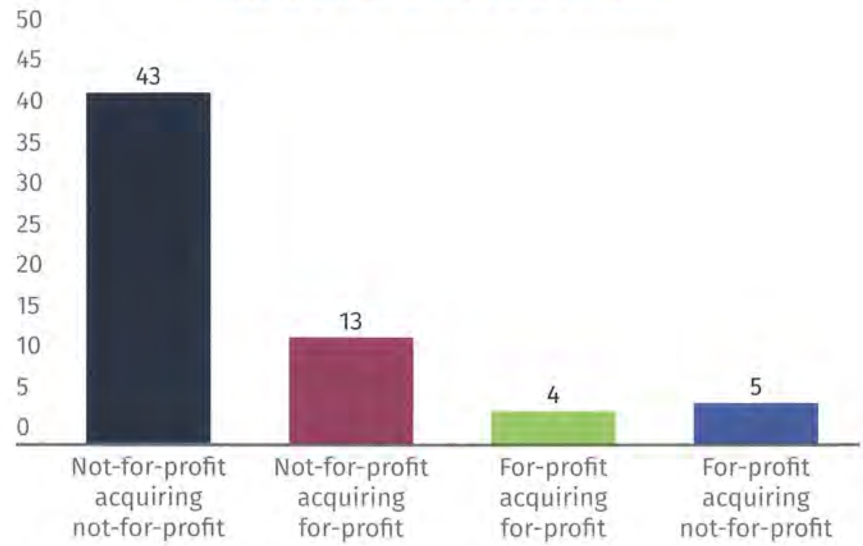
> *Private equity firms working to ensure high-quality, affordable healthcare through responsible M&A activities must be ready to demonstrate those benefits in any proposed deal, but understand that they may meet some initial skepticism from government authorities.*

In response to this laser-like focus by government authorities, private equity firms should be prepared to adapt investment strategies accordingly and to develop procompetitive justifications for all their transactions. For example, firms may more often choose to invest in healthcare systems by holding non-controlling interests. Though the *Merger Guidelines* specifically address this strategy, it is undoubtedly more difficult for authorities to challenge non-controlling ownership of multiple entities than, for instance, direct control of one entity with a high market share. Even with a non-controlling interest, private equity firms can provide much-needed

capital to help improve the quality of care provided to patients.

Ultimately, a central consideration of any private equity firm seeking to invest in a healthcare system should be the procompetitive benefits that are possible only through the proposed transaction. Private equity firms working to ensure high-quality, affordable healthcare through responsible M&A activities must be ready to demonstrate those benefits in any proposed deal, but understand that they may meet some initial skepticism from government authorities.

Not-for-Profit/For-Profit Deals in 2023



Source: Data from Kaufman, Hall & Associates, LLC

Implications for Hospital Boards

Mergers and acquisitions and outside investments in hospitals and health systems have increased significantly over the last several years. Each hospital and system has its own unique market, needs, and strategies. Regardless, the delivery of healthcare services has evolved over the last decade and will continue to do so and therefore, hospital board members have a bigger role than ever to play as their organizations address these challenges. With the increasing need for many hospitals to partner coupled with the heightened scrutiny from the FTC, DOJ, and state regulators, board members have a more complicated landscape to navigate than ever before. As boards consider partnerships for the entire hospital or system or for ancillary services, there are key considerations to make:

Boards need to carefully evaluate any potential partner as always, but in light of this new regulatory environment where whole hospital acquisitions are being more carefully evaluated and private equity ownership is being highly scrutinized, transactions will require additional due diligence.

- **It's a marathon**: Think long-term in tandem with the short-term fixes that the hospital or system may need. Repeated short-term fixes may jeopardize long-term goals. Identify the ideal end game and several alternatives and work backwards to assess what actions need to be taken in the near- and long-term to succeed.
- **Increased due diligence**: Boards need to carefully evaluate any potential partner as always, but in light of this new regulatory environment where whole hospital acquisitions are being more carefully evaluated and private equity ownership is being highly scrutinized, transactions will require additional due diligence. For instance, a private equity-backed hospital system or ancillary service provider may be the perfect fit for your needs, but be aware of the added regulatory scrutiny and how that might impact the necessary due diligence and timeline to closing. Address regulatory compliance and minimize the impact on day-to-day operations to the greatest extent possible by the strategic decision making being undertaken.
- **Focus on mission**: Remember your duties to the mission of the hospital or system and the provision of high-quality care in the geographic area served by the hospital or system. Does the partnering organization allow your system to advance its mission and provide the best care to patients?
- **Transparency and communication**: Open communication with patients, staff, and the community is crucial regarding any potential transaction or partnership, particularly if private equity investment is involved. Make a plan to communicate with your constituents, including physicians, employees, and the public, and follow through on that plan regularly. Identify potential roadblocks and work proactively to address them. Being reactive lengthens the process and lessens the prospects for success.
- **Healthcare expertise and counsel**: Surround yourself with experts who have helped hospital management and boards with creative financial, operational, and legal decision making to preserve care, as well as those experienced in navigating the particular nuances that come with private equity investments to fully evaluate the various partner options and deal structures available. While every situation has its own unique considerations, surrounding yourself with counsel who has advised on these types of transactions will allow you to more carefully navigate each situation and ultimately increase the odds of a successful transaction.

While hospitals and smaller health systems undoubtedly face unprecedented challenges today, these times also present unique opportunities if tackled in a strategic and methodical way. The future of private equity involvement in healthcare remains uncertain. Hospital boards must be well-informed about the potential risks and take a proactive approach to ensure patient care and community well-being remain top priorities.

TGI thanks Bill Katz, Partner, Antitrust, Anna Hayes, Associate, Antitrust, and Eric Scalzo, Partner, Healthcare Transactions, from Holland & Knight for contributing this article. They can be reached at bill.katz@hklaw.com, anna.hayes@hklaw.com, and eric.scalzo@hklaw.com.

Aligning Management and Governance Structures for System Success

*By Pamela R. Knecht, **ACCORD** LIMITED*

The American Hospital Association (AHA) reports that 68 percent of hospitals in the United States are now part of a health system.[1] Some hospitals have joined or created systems because of financial challenges (e.g., reduced reimbursement, increased workforce expenses, and expensive information technology); however, most systems were developed because their leaders believed that model would allow for better care at a lower cost.[2] In fact, data from AHA indicates that through hospital acquisitions, systems *have* been successful in reducing costs, lowering expenditures, improving quality, and increasing access to services.[3]

However, too often, the promised benefits of "systemness" and "integration" are not all realized. There are many potential reasons that some systems fail to achieve their desired outcomes. This article focuses on one problem that has not received enough attention: insufficient alignment among the organizational structures.

Within a health system, there are typically four levels of organizational structure/design:

1. Legal, corporate entities (e.g., corporations)
2. Governance structure (e.g., boards and their committees)
3. Management structure (e.g., boxes on the staffing chart)
4. Clinical structure (e.g., medical staff structures)

This article addresses common misalignment between the governance and management structures.

Case Study: Structural Misalignment

A case study will help explain a typical situation in which the governance and management structures were not aligned, causing suboptimization of integration efforts.

The CEO of a Midwestern health system had begun to implement the board-approved vision of increased systemness by changing the management structure to a more centralized model. As with most health system journeys, she started with the non-patient-facing functions, such as human resources, finance, and information technology. The CEO named system-level executives and decided that each individual hospital's senior management in these functions would report to the system Chief Financial Officer, Chief Human Resources Officer, and Chief Information Officer. In addition, the administrative head of each hospital was renamed the President (not CEO) and those individuals now reported to the system CEO.

Although these management structure changes were in line with the vision to become more of an integrated, centralized system, problems arose because the governance structure was still decentralized. Each of the seven hospitals had a board that retained significant authority for key governance tasks, such as approving the annual budget, capital plan, strategic plan, external audit, and their executives' compensation. In addition, the hospitals' bylaws still stated that their boards oversaw the hospital CEO's hiring and evaluation, and if necessary, replacement.

Tension built at both the system and local levels. For instance, the system CFO was frustrated because she was trying to build the annual budget for the whole enterprise but was not receiving the needed data from a local hospital finance director. The hospital board's finance committee chair was frustrated because he thought that their board had the authority to create and approve their own budget. The local finance director felt caught in the middle because he was waiting for approval of their proposed budget from the hospital board's finance committee before providing that information to the system CFO.

The same scenario was playing out in multiple functional areas. One hospital board's executive compensation committee was working with a different compensation consultant than the system board's compensation committee, making it difficult to align compensation approaches across the system. Another hospital board's strategic planning committee had developed their own situational assessment and vision that was not consistent with the system's view of the external and internal environments or its 10-year strategic plan.

To complicate matters, some local hospital presidents and some medical staffs liked having their own board. Physicians could appeal to the board members they knew when they wanted approval of expensive medical equipment that the system had declared redundant. Some hospital presidents wanted to retain more local decision-making authority and used their boards to delay or fight implementation of system initiatives.

››› KEY BOARD TAKEAWAYS

- Too often, health systems are sub-optimized because their governance and management structures are not aligned with each other and/or the system's strategy.
- To identify potential misalignment, board members and managers need to be engaged in education and discussion about how best to support achievement of the system's vision and strategy.
- Board and executive leadership should both make changes to their structures and practices to ensure all are rowing in the same direction.

Diagnosing the Problems

In response to these tensions, the system CEO and board leadership authorized an external assessment to diagnose the problems and recommend solutions. As a result of that study, they realized that the decentralized governance structure had become a barrier to the management team's ability to implement the strategic vision of a more integrated system.

Granted, the hospitals' bylaws stated that the system was the sole corporate member and had some reserved powers over the hospital boards. But the hospital boards were still functioning as if they were standalone instead of part of a system. For instance, hospital board committees existed for governance responsibilities that had been delegated to the system board (e.g., executive compensation).

Craig Deao, who co-led Studer Group's journey to become a recipient of the Malcolm Baldridge National Quality Award, shared his perspective on this and similar situations.[4] "Systems are created, bylaws are drafted, all designed to enable the organization to operate as a system; but the governance structure

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1 AHA, "2024 Fast Facts on U.S. Hospitals," 2024.
2 See Pamela R. Knecht, "Remind Me: Why Do We Need Systemness?," System Focus, The Governance Institute, June 2018.
3 Sean May, Monica Noether, and Ben Stearns, "Hospital Merger Benefits: Econometric Analysis Revisited," AHA, August 2021.
4 Craig Deao is Managing Director at Huron Consulting Group.

Taking the Lead...

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3. Artificial Intelligence (AI)
Building on patient and clinical data, health systems can use AI tools to help identify and enable opportunities for improving health equity—in ways previously unimaginable.[5] But without diligent oversight and careful scrutiny, these tools can easily perpetuate, increase, and create inequities.[6] In short, they can turn well-intended efforts into a negative impact on the community.

Board members can provide a voice for the communities their hospital or health system serves. They can start by understanding the potential risks of AI use. Then, they should ensure the organization establishes the necessary guardrails, collaborations, and impact analysis for AI use.

4. Workforce
Hospital and health systems' strategies to improve health equity for the community must go hand in hand with cultivating equity in their own workforce.[7] Increasing diversity, equity, and inclusion at all levels of the organization helps hospitals and health systems reflect the communities they serve. This, in turn, helps reduce healthcare disparities and increases employee engagement.

Successful healthcare organizations evaluate and modify organizational policies that have historically disadvantaged certain groups, attract and hire employees who represent the populations their organization serves, and address specific social drivers of health for their employees. Doing so delivers value for patients, employees, and the organization. For example, connecting employees to community-based social health resources saves employers nearly $2,500 per employee per year.[8]

Build from Discussions to Action

As a board member, you bring valuable insights to discussions with the C-suite. You may also help build the community connections and referrals necessary to promote health equity. Start with candid conversations, then build your healthcare organization's strategic approach and outline actionable steps for success.

TGI thanks Duane Reynolds, Chief Health Equity Officer, Chartis, for contributing this article. He can be reached at dreynolds@chartis.com.

5 Garth Graham, Bret Anderson, and Tom Kiesau, "AI and Health Equity: How Health System Boards Can Mitigate Risks and Advance Benefits," Chartis, April 3, 2024.
6 "AI Roundtable: Exacerbate or Address Health Inequities? AI's Risks and Opportunities," Chartis, July 5, 2023.
7 Valerie Montgomery Rice, et al., "Advancing Equity in the Workplace: Five Questions Health System Boards Should Ask Leaders," Chartis, April 3, 2024.
8 Laurie Zephyrin, Josemiguel Rodriguez, and Sara Rosenbaum, "The Case for Diversity in the Health Professions Remains Powerful," The Commonwealth Fund, July 20, 2023.

You Can't Cut Your Way Out...

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non-organic growth through acquisition or partnership of specific services or facilities.

A significant number of large organizations are seeking partners that have complementary capabilities, needs, and perspectives after a pause in activity during the pandemic. At the same time, many midsized or smaller organizations seeking to gain those capabilities have shifted their perspective on independence. With 20 announced hospital and health system transactions, Q1 2024 showed a significant uptick in M&A activity and represents the strongest Q1 since 2020.[5]

Many organizations have seen significant turnover in both clinical and administrative staff—including executive leadership—creating a significant talent gap that is also driving some new partnerships and mergers. Nearly 150 CEOs left their hospitals and health systems in 2023, according to a report by Challenger, Gray & Christmas.[6]

As organizations consider partnerships and other coordinated efforts, the more constrained operating environment means they will need to apply a discerning lens to decide how to invest their resources. At the same time, the rapidly evolving outlook—including the strategic moves of other marketplace participants—requires a commensurate response, given that inactivity is a decision in and of itself.

Two types of innovative partnership types have been accelerating rapidly:

- **Non-acute care partnerships with specialty providers and start-ups.** No two partnerships are alike. We are seeing everything from arrangements with other providers/competitors to partnerships with new start-ups, and structures ranging from loose "arms-length" affiliations to full-asset mergers are being assessed.
- **Payer–provider partnerships and affiliations** designed to create and realize value through the delivery of high-quality care at a sustainable cost. These efforts are designed to help providers increase access to covered lives and the premium dollar, while helping insurers expand their presence at the point of care.

At the same time, many organizations are repositioning or even considering exiting some lines of business that may not offer the same opportunities for long-term success (e.g., senior living/skilled nursing, outreach laboratory, or behavioral health). While many of these services are critical to the continuum of care, organizations are finding new and innovative ways to partner with specialty organizations to ensure continued access outside of an ownership model. Organizations seeking to pursue more targeted growth may need to decide where to focus and where to scale back.

TGI thanks Courtney Midanek, Managing Director, John Poziemski, Managing Director, and Max Timm, Senior Vice President, Kaufman, Hall & Associates, LLC, for contributing this article. They can be reached at cmidanek@kaufmanhall.com, jpoziemski@kaufmanhall.com, and mtimm@kaufmanhall.com.

5 Anu Singh, "M&A Quarterly Activity Report: Q1 2024," Kaufman Hall, April 11, 2024.
6 Jay Asser, "Hospital CEO Turnover Not Slowing Down," HealthLeaders, February 8, 2024.

Physicians on the Board...

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with the organization's conflict-of-interest policies.

Lately, federal officials have ramped up their scrutiny of potential anticompetitive activity in the healthcare sector. Physicians serving on the hospital governing body are in a position to undermine the business success of competitors on the medical staff or those who otherwise practice in the hospital's service area. Decisions that can suggest anticompetitive behavior include (but are not limited to):

- The opening or closing of particular clinical services
- Determinations regarding medical staff membership and privileges
- The selection of other physicians to serve on the board
- Decisions about adverse actions or disciplinary measures against particular medical staff members

In some cases, even access by a physician board member to competitively sensitive information about a competing practitioner can raise concern under antitrust laws. As a prudent practice, physician board members should recuse themselves from discussion and decision making that can give even the appearance of unlawful anticompetitive behavior.

Legal barriers are not the only concerns impeding the appointment of physicians to the hospital board. Some experts believe that healthcare professionals do not have the necessary management skill set to work successfully on boards. This mindset is being challenged by a growing cadre of physicians who specifically seek out management training and experience in their professional careers.

The Value of Physicians in Governance

While this article focused on barriers to physician board membership, the benefits of physician participation in governance are substantial.[3] Many of the concerns regarding physician members can be ameliorated and many of the benefits can be obtained through the use of one or more physicians who are independent "outsiders." In these times of widespread disengagement, it is important to recognize that physicians are most likely to step up and be drivers of hospital success when they feel they have influence at the highest levels of the organization. History and legal hurdles need not be insurmountable obstacles and the thoughtful board will find there are numerous avenues for including physicians in the critical tasks of governance.

TGI thanks Todd Sagin, M.D., J.D., President and National Medical Director of Sagin Healthcare Consulting and Governance Institute Advisor, for contributing this article. He can be reached at tsagin@saginhealthcare.com.

3 See Kim Russel, *The Voices of Physicians on Your Board: Maximizing a Hidden Asset*, The Governance Institute, Summer 2020.

Aligning Management and Governance...

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still reinforces optimizing each piece of the system rather than the system as a whole. This goes directly against modern system theory espoused by experts such as Russell Ackoff who said, 'The performance of a system doesn't depend on how the parts perform taken separately, it depends on how they perform together—how they interact, not on how they act, taken separately. Therefore, when you improve the performance of a part of a system taken separately, you can destroy the system.'"

The local hospitals and boards described above were focused on their individual success, and by functioning this way, they were suboptimizing the system's performance.

The Fix

The first step in fixing these problems (and ultimately achieving the benefits of systemness) was to ensure that the strategy was understood and shared by all. The system CEO, executives, and board leaders hosted an all-boards retreat that included education on and discussion about the future healthcare environment, the advantages of systemness, the system's strategy, and trends in health system governance. Each table discussion was led by a facilitator who encouraged participants to ask questions about the strategy and to identify possible implications of the strategy for the boards and their committees.

Subsequently, a governance task force worked with an external consultant to clarify the strategy, develop a case for change, create design principles, and explore governance structure options. The task force ultimately recommended governance changes that created more alignment with the strategy and the management structure. For instance, hospital boards became focused on oversight of quality, safety, patient satisfaction, and community health needs identification. The parent board and its committees now handle strategic planning, operating and capital budgeting, audit, and executive compensation, among other duties. Since the hospital boards were no longer handling those tasks, they eliminated the associated committees. Well-meaning hospital board committee chairs and managers were no longer doing work that was redundant with the system board and executives, so tensions disappeared.

In turn, the system CEO worked with her hospital presidents and other executives to clarify the management structure and processes to be more aligned with the governance structure. In addition, they engaged the hospital boards and management teams in coordinated initiatives to learn about local needs while advancing integration across the system.

With new clarity of purpose, roles, and authority, those serving in governance and management positions were better able to work together towards a common vision. And, when surveyed, board members and managers throughout the system felt that their contributions were more valued and valuable. As a result, the organization had moved much closer to optimizing the systemness needed to improve their communities' health.

*TGI thanks Pamela R. Knecht, President and CEO, **ACCORD** LIMITED, for contributing this article. She can be reached at pknecht@accordlimited.com.*

Physicians on the Board: Barriers Abound

By Todd Sagin, M.D., J.D., Sagin Healthcare Consulting

Members of the lay public are often surprised to learn that physicians typically play a small role in hospital governance. While leadership roles for physicians have been expanding in many health systems, physician membership on the board appears to be diminishing. The Governance Institute's 2023 Biennial Survey of Hospitals and Healthcare Systems noted that "the average number of physicians on the board has declined overall since 2017." The survey reported that the average number of physicians on the board (all types of physicians including the CMO and "outside" physicians) is 2.4.[1]

Not only are the number of doctor board members typically small, it is also not uncommon for at least one of those physician board members to be the Chief or President of the medical staff who serves for a limited period coinciding with his or her time in office. This means that at least one physician board member has a minimal tenure to learn the skills of good governance and build collaborative relationships with other board members.

> *In recent decades, the IRS has liberalized its guidance but most legal experts advise non-profit boards to limit "insider" membership to less than 50 percent of board membership.*

At a time when medical staff trust in hospital governing boards is at a dramatic low[2] and there is great need for board expertise on issues such as quality, patient safety, workforce recruitment/retention, and clinical strategic planning, it may seem puzzling that physicians are not sought more often for board positions. However, there are several historical and legal reasons that likely contribute to this limited presence.

Hurdles to Physician Membership

In non-profit healthcare institutions, physician board participation has typically been restricted by tax rules that require the boards of such organizations to minimize the number of "insiders" serving in governance. "Insiders" are those whom the IRS sees as financially tied to the hospital (e.g., through direct employment, contracts for services, or use of the institution's facilities to generate income). The government's concern is that such insiders will make decisions for the organization based on their own private economic interests rather than prioritizing their fiduciary duty of loyalty. The IRS considers any member of the active medical staff to be an "insider."

Historically, IRS rules limited physician representation on non-profit hospital boards to 20 percent of board members. This set a pattern of low physician participation on such governing bodies. However, in recent decades, the IRS has liberalized its guidance but most legal experts advise non-profit boards to limit "insider" membership to less than 50 percent of board membership. Of course, physicians are not the only potential insiders who might serve on the board. Individuals such as the CEO, Chief Nursing Officer, or any lay board member with significant financial ties to the hospital must also be counted to assure that a majority of board members are independent. Recent trends in governance have seen many boards become smaller, while also increasing their percentage of independent board members. As a result, it is not surprising that the actual number of physicians on the typical hospital board has changed little over the years, even as IRS restrictions have lessened.

In addition to federal IRS rules, individual states sometimes have their own regulations for non-profit institutions, including their own tests to determine if a director is "independent." Furthermore, tax exemptions for hospitals have become controversial in recent years, and many governing bodies are being careful not to add fuel to this fire by running afoul of any regulations defining board member independence and objectivity.

All board members have a fiduciary duty to avoid conflicts of interest and disclose them where they occur. Conflicts of interest may occur more frequently with physicians who are members of the medical staff and who provide clinical care to patients at the hospital. Often physician board members are asked to vote on the approval of new equipment, new clinical programs, real estate issues, actions regarding medical staff privileges, and other matters that could affect their own income or that of their colleagues or referral partners. Sorting out where various conflicts of interest may lie for doctors on the board can require diligence and care.

A conflict-of-interest transaction is defined by the Model Non-Profit Corporation Act as, "a transaction with the corporation in which the director of the corporation has a direct or indirect interest." Boards that have physician members must be especially careful to adopt rigorous disclosure policies and should consider spending extra time educating physician board members on the importance of compliance

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››› KEY BOARD TAKEAWAYS

- Physicians potentially bring numerous strengths to membership on a hospital board, including familiarity with conditions on the hospital floors, clinical knowledge to inform strategic planning, training regarding quality and safety, and the ability to communicate effectively and build trust with the hospital's professional community.
- The trend to minimize physician membership of hospital boards is exacerbating the growing distrust evident between many medical staffs and hospital leaders.
- IRS rules limit the number of "insiders" on the board (including medical staff physicians), but physicians who are not "insiders" can be recruited to serve as board members.
- Physician engagement with the governing body can be promoted not only through physician board membership, but also through invitations to participate in board retreats and planning sessions, creation of physician advisory bodies, board member attendance at general medical staff meetings, and invitations to physician leaders to periodically attend board executive meetings.

1 Kathryn Peisert and Kayla Wagner, *Think Bold: Looking Forward with a Fresh Governance Mindset*, The Governance Institute's 2023 Biennial Survey of Hospitals and Healthcare Systems.

2 Todd Sagin, "Is Your Hospital Losing the Trust of Its Physicians?," *BoardRoom Press*, The Governance Institute, December 2023.